

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033138

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 254

Primary Registration District No. 3052

Registrar's No. 315

FILED SEP 12 1963

1. PLACE OF DEATH a. COUNTY Pettis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Pettis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Sedalia		Length of stay in 1b 41 Years	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Bothwell Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ARTHUR C CLARENCE SPRY		4. DATE OF DEATH Month Day Year September 10, 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-20-1879
9. AGE (last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
11. BIRTHPLACE (City and state or country) Fayette, Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME George Spry		13b. MOTHER'S MAIDEN NAME Vitha Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		17. INFORMANT Mrs. Birdie Spry	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) arteriosclerotic Cardiovascular disease DUE TO (c) disease		14. NAME OF HUSBAND OR WIFE Birdie Vinson Spry	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour s.m. p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Sedalia	
21. I attended the deceased from 1955 to State and last saw her/him live on Sept 9-63		22. DATE SIGNED 11 Sept 63	
22a. SIGNATURE Karl B. Jones MD		22b. ADDRESS Sedalia Mo.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 9-11-1963	23c. NAME OF CEMETERY OR CREMATORY Crown Hill Cemetery	23d. LOCATION (City, town, or county) Sedalia, Missouri
24. FUNERAL DIRECTOR D.W. Heckart		25. DATE RECD. BY LOCAL REG. Sept 11, 1963	
26. REGISTRAR'S SIGNATURE Frances Shelby for M. Anderson			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

SEP 13 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John R. Farmer Jr.

Licensed Embalmer No.

5173

P. O. Address

Sedalia mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.